

have both dyskaryosis and warts. A group with both dyskaryosis and warts is not included in the hypothetical example. If it had been, assuming that dyskaryosis and warts were independent risk factors for CIN, the relative risk for the group with both dyskaryosis and warts would be $16 \times 4 = 64$. This would imply that 100% of the group with both dyskaryosis and warts would have CIN. The 2×2 table would now be:—

	CIN	No CIN
Warts	55	45
No Warts	20	30

giving a relative risk of 1.83—more than 10 times the 0.17 obtained by Dr Renton and his colleagues from their inappropriate example.

We thank your correspondents for their combined interest in our paper.

- 1 Jenkins D, Tay SK, McCance DJ, *et al.* Histological and immunocytochemical study of cervical intraepithelial neoplasia (CIN) with associated HPV6 and HPV16 infections. *J Clin Pathol* 1986;39:1177–80.
- 2 Robertson AJ, Anderson JM, Swanson BECH, *et al.* Observer variability in histopathological reporting of cervical biopsy specimens. *J Clin Pathol* 1989;42:231–8.

National STD trends in Zambia 1987–89

In their review of national STD trends in Zambia, Matondo concludes that there has been a decline in STDs since 1987.¹ This, it is stated, has occurred in spite of the increase in the number of STD clinics.

I wish to point out, however, that the data presented do not make a strong case for reaching this conclusion. The figures presented are absolute numbers of total cases and number of cases of each particular condition. This does not clearly show any shift in any direction as the data are influenced by various qualitative and quantitative factors. The assertion that because all clinics reported a decline suggests a genuine decline in STDs is not valid and needs clarification. This assertion can only be proved by establishing that a similar decline in out-patient attendances did not occur. It is known, for instance, that the economic situation in Zambia worsened during the period under study. This resulted, as expected, in a reduction in the resources allocated for health services. Consequently, there was a reduction in the availability of drugs and personnel with a subsequent decrease in hospital utilisation in some years. Health facility attendance for all conditions declined over the years though not uniformly. Although a decline in numbers of STD attendances did occur during the period in question, there was no decline if taken as a proportion of the total number of attendances. The decline reported is therefore an apparent decline and not a genuine one.

Individuals who do not seek medical care from health centres and hospitals go elsewhere, as Dr. Matondo rightly points out. It is necessary, therefore to study STD trends among private practitioners, traditional healers and other informal health workers before being conclusive on declines. It is possible that there is an inverse relationship between the number of people who attend hospitals and those seek treatment elsewhere.

Although the AIDS control programme in Zambia was established in 1986 and the

STD programme in 1980, it was not until 1988 that massive health education campaigns were initiated. It is not likely that there were positive outcomes of these initiatives as early as 1988. As STD trends can be used as a surrogate marker for sexual behaviour change, trends in HIV infection also can be used as a proxy indicator of STD trends. Contrary to Matondo's findings, HIV surveillance data have shown increases in sero-prevalence rates in antenatal clinic attenders and blood donors during that period.²

In a paper presented at the International Conference on AIDS in Africa, Kinshasa, we reviewed data from STDs in Zambia and were able to conclude that it was possible to infer wrongly that a decline had occurred if the data did not take account of various quantitative and qualitative factors.³ In addition we showed that when rates are calculated using out-patient attendances as denominators fluctuations, and not a steady decline in trends, is noted.

It is for this reason that the data presented should have considered rates and not absolute numbers. In calculating the rates, the total number of individuals attending a particular site for any reason should be taken as a denominator. This is so that the biases introduced by factors that affect hospital services utilisation and provision are considered.

I wish to suggest, therefore, that Matondo re-analyse his data and use out-patient attendance for each period as a denominator. This will allow comparisons of rates as opposed to absolute numbers. In addition we suggest that tests of significance are performed on the data to validate whether any changes in trends are statistically significant and present a genuine decline in STD trends.

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- 1 Matondo P. National STD trends in Zambia: 1987–89 *Genitourin Med* 1992;68:192–8
- 2 Tembo G, Hira S. *Epidemiological review of HIV infection in Zambia*. V International Conference on AIDS, 1989, Montreal, Canada.
- 3 Tembo G, Hira S, Van Praag E. *Monitoring STD trends: quantitative and qualitative issues*. V International conference on AIDS in Africa, Kinshasa, 1990.

HIV infection in Tirupathi, India

I refer to the comments of Ravi Sockanathan, *Genitourin Med*, 1992;68:199. I must point out that vast numbers of non-Hindus also exist in Tirupathi and these include Muslims, Christians and others. It is therefore completely inappropriate to single out Hindus. Also, in a country with so much illiteracy as India, posters on sexual topics would be ill received. Television might help but what is really needed is education of the population as a whole. In the field of genitourinary medicine in particular much attention needs to be paid to differences between cultures.

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Sockanathan replies:

I refer to the comments of Dr S Tharakaram and value his suggestions, indicating that TV programmes and education of the population

as a whole would raise the public awareness of the prevalence of HIV infection in Tirupathi and South India. However, he has failed to appreciate that holiday makers from Europe who are unaware of the prevalence of the disease in these areas, will certainly not be influenced by health education campaigns. Radio and television programmes may be a source of information for the local population only. Therefore the lay press published in the western world indicating the prevalence of the infection in these areas will certainly increase the awareness amongst holiday makers and some pilgrims!

Illiteracy in India, should not form a barrier for health education programmes. A standard protocol for the prevention and control of sexually transmitted diseases¹ should be followed in the tropics and developing countries as recommended by the World Health Organisation.

Although the epidemiology health education programmes of sexually transmitted diseases in the tropics vary from that in the developing countries,² it is well known that British yardsticks are commonly used in many parts of the world including India.

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- 1 Bennett FJ. Control of sexually transmitted diseases in the tropics and developing countries. In *Sexually Transmitted Diseases in the Tropics* Osoba AO, (ed). Bailliere; London. 1987.
- 2 Wilcox RR. VD education in developing countries. A comparison with developed countries. *Br J Venereal Dis* 1976;52:88.

Exophytic cervical warts—an indication for colposcopy?

In their recent paper, Evans *et al* conclude that external anogenital warts are not a risk for subclinical cervical HPV infection or for CIN and therefore not an indication for colposcopy.¹ In contrast to external exophytic warts, cytological evidence of cervical HPV infection was strongly associated with all grades of CIN. The authors suggest that external exophytic anogenital warts may in fact have a protective effect on the genesis of CIN. However, Evans *et al* make no comment on the relationship of exophytic cervical warts, as distinct from subclinical cervical HPV infection, to CIN.

Approximately 6% of women with genital warts may have exophytic cervical warts.² The practice at this unit is to perform colposcopy on all women with clinically apparent exophytic cervical warts regardless of the result of cervical cytology. In a preliminary study we reviewed the cytological, colposcopic and histological findings of all patients who had colposcopy performed primarily for this indication. Thirty four patients were identified over a 6 month period, of whom 82.4% had concomitant vulval warts. Only four (11.7%) women had cytological evidence of HPV infection. Dyskaryosis was found in 9/34 (26.5%). Twelve patients had normal cytology, two of whom had CIN (grade 2) on histology (negative predictive value 83.3%). Nineteen patients had low grade smears (inflammatory/borderline, wart virus infection, mild dyskaryosis) of whom four had CIN 1 and two CIN 2. Overall 9/34 (26.5%) women

with clinical cervical warts had histologically proven CIN (five CIN 1, four CIN 2).

Current recommended NHS guidelines for colposcopy include dyskaryosis or a clinical suspicion of invasive cervical disease.³ We suggest that cytological diagnosis is inaccurate in the presence of exophytic cervical warts and that their existence is an indication for colposcopy.

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- 1 Evans BA, Bond RA, MacRae KD. A colposcopic case-control study of cervical squamous intraepithelial lesions in women with anogenital warts. *Genitourin Med* 1992;68:300-4.
- 2 Oriel JD. Natural history of genital warts. *Br J of Venereal Dis* 1971;47:1-13.
- 3 Duncan ID, ed. *NHS Cervical screening programme. Guidelines for clinical practice and programme management*. March 1992, Oxford. National Coordinating Network, 1992.

MSSVD REPORT

The Medical Society for the Study of Venereal Diseases Report of the Honorary Secretary to the 71st Annual General Meeting held at The Royal Society of Medicine on 23 October 1992

Over the last year the membership of the Society has increased by 28, to 610; of these 158 are overseas members, from 43 countries. Professor Detlef Petzoldt was elected an Honorary Life Member of the Society. The death of Dr Joe Ribeiro was reported in December 1991.

Five ordinary general meetings were held and these were well attended, each by between 102 & 170 members. The Society is grateful to the Royal Society of Medicine for allowing use of The Barnes Hall and to Brocades Ltd, Janssen Pharmaceutical Ltd., Wellcome Medical Division and Perstorp Pharma Ltd for providing financial support.

The Janssen prize for the best paper presented by a junior member at the November OGM was shared between Dr Richard Coker of St Mary's Hospital, London and Dr Jyoti Dhar of Liverpool.

The MSSVD Undergraduate prize was awarded to Dr Kevin Frayne of the University of Wales College of Medicine, Cardiff.

The Spring Meeting was held in Dublin, Ireland from 18-21 June 1992. Attendance figures again rose with 223 delegates and 39 guests attending the meeting. Forty-four papers were presented orally and 82 as posters. The prize for the best oral presentation was awarded to Dr K Ward of Belfast and the prize for the best case report to Dr J Arumainayagam of Bristol. The prize for the best poster was shared between Dr K Rogstad of Nottingham and Dr P G Pandit of Birmingham. The social events were greatly enjoyed and the Society thanks Dr

Fiona Mulcahy for hosting such an excellent meeting. The Society is grateful to the pharmaceutical companies who provided generous sponsorship—in particular Bayer UK Ltd., Bristol Myers Squibb Pharmaceuticals Ltd., Glaxo Laboratories Ltd., Janssen Pharmaceutical Ltd., Lederle Laboratories, Perstorp Pharma Ltd., Pfizer Ltd., Schering-Plough Ltd., Smith Kline Beecham Pharmaceuticals Ltd., Syntex Pharmaceuticals Ltd., and the Wellcome Medical division.

The Harrison lecture was given by Dr J D Oriel at The Royal College of Physicians on 24th April 1992. Entitled *The Future of Syphilis* it was very well received. Fifty members attended the dinner which followed.

The eleventh Genito-Urinary Medicine study weekend for doctors in training was held at Tetley Hall, The University of Leeds on 4 and 5 April 1992. The meeting was attended by 100 participants who enjoyed an interesting scientific programme. The society is grateful to Bayer UK for providing full financial support. The next meeting will be held on 3-4 April 1993 in Leeds and Bayer has again agreed to support the meeting.

A joint Anglo-French meeting, organised by Professor Alain Le Faou and Dr Michael Waugh, was held in Strasbourg, from 2-4 October 1992 with papers presented from both countries. The meeting was attended by 70 delegates and was most successful.

The Council of the Society met on seven occasions and amongst the items discussed were the following:

- Medical training in genitourinary medicine
- Recruitment to the specialty
- A model job description for consultants
- The role of clinical assistants in genitourinary medicine
- Overseas doctors in genitourinary medicine
- Regional representation on Council of MSSVD
- The process of Council elections
- A National Association for Genito-Urinary medicine
- The annual subscription to the Society
- HIV infection and tuberculosis
- Goals, indicators and targets for sexually transmitted diseases and
- The White Paper 'The Health of the Nation'

Genito-Urinary medicine, volume 67, in 1992 contained 333 pages, had 72 original articles, 5 editorials, 9 reviews, 6 AIDS clinico-pathological conferences, 6 conference reports or miscellaneous papers and 23 letters, the correspondence column being given more space and prominence. Another change in 1991 was the introduction of structured abstracts. The journal continued to publish papers on a wide range of sexually transmitted disease, including the tropical STDs, attracting papers from around the world with a substantial increase in submissions from Eastern Europe. At the end of 1991 the cover design and size of the journal were changed, producing a more up to date appearance for the journal. The Society thanks Professor Mindel for his continuing work as Editor to improve the style and content of the journal, and wishes him well in his new post in Sydney, Australia.

It is now time to give my personal thanks to those people who have supported me in

my role as Honorary Secretary over the last 12 months. I should first like to thank the other Officers of the Society: My year working with the President, Dr Harris has been instructive as well as enjoyable. The support of the Treasurer and Assistant Secretary has continued to be invaluable, as has that of the whole Council who must be congratulated on getting through some long and arduous agendas. Finally but most importantly I must again thank the secretaries without whose support I would have been unable to fulfil my role. Well known to many of you they are Elaine Ghent, Nancy McEwan and most recently Gina Alley.

This is my last meeting as Honorary Secretary of this Society, a post which I have enjoyed for the last three years. In this time the Society has continued to expand and develop, but the academic interests of the Society have been constrained by the time the Officers and Council of the Society have been able to give to duties which will now be taken on by the Association. My successor will be able to bring new ideas and enthusiasm to the post of Secretary of MSSVD, developing the principles on which the Society was established: of "promoting the study and practice of the art and science of diagnosing venereal diseases". I am pleased to be able to hand over to Dr Tom McManus; I am sure he will serve you well.

M J GODLEY

NOTICE

Royal Society of Medicine

A conference on *Emerging Patterns of Heterosexual HIV Infection and Transmission* will be held 29-31 March 1993.

Details obtainable from Miss L Raine, the Royal Society of Medicine, 1 Wimpole Street, London W1M 8SE, telephone 071-408 2119.